STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005049	A. BUILDING _____ B. WING _____	C 06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH TIPTON HOSPITAL IN(	1000 S MAIN ST TIPTON, IN 46072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 1 (one) State hospital complaint investigation. Complaint: #IN00106768 Substantiated; no State deficiencies cited related to the allegations. Facility: #005049 Date: 6/7/2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Indiana University Health Tipton Hospital Inc. is in compliance with 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules. QA: claughlin 06/29/12	S 000		